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1.0 Description of the Service

Anesthesiology is the practice of medicine dealing with, but not limited to, the following:

a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures
b. The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations
c. The clinical management of the patient unconscious from whatever cause
d. The evaluation and management of acute or chronic pain
e. The management of problems in cardiac and respiratory resuscitation
f. The application of specific methods of respiratory therapy
g. The clinical management of various fluid, electrolyte, and metabolic disturbances

Anesthesia services include the anesthesia care consisting of preanesthesia, intraoperative anesthesia, and postanesthesia components. Anesthesia services include all services associated with the administration and monitoring of the anesthetic/analgesic during various types/methods of anesthesia. Anesthesia services include, but are not limited to, general anesthesia, regional anesthesia, and monitored anesthesia care (MAC). These services entail a preoperative evaluation and the prescription of an anesthetic plan; anesthesia care during the procedure; interpretation of intra-operative laboratory tests; administration of intravenous fluids including blood and/or blood products; routine monitoring (such as electrocardiogram (ECG), temperature, blood pressure, pulse oximetry, capnography, end-tidal infrared gas analysis, mass spectrography, bispectral electroencephalography, and transcranial Doppler); immediate post-anesthesia care, and a postoperative visit when applicable.

Time-based anesthesia services include all care of the patient until the anesthesiologist, resident or certified registered nurse anesthetist (CRNA) is no longer in personal attendance.

Anesthesia services are separate and distinct from the administration of moderate sedation, which can be administered or supervised (21 NCAC 36.0226) by any non–anesthesia-credentialed provider, as long as the supervising physician is credentialed to provide moderate sedation services at the site of the practice location.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a

condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

   Basic Medicaid Billing Guide: http://www.ncdhhs.gov/dma/medbillcaguide.htm

   EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

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3.1 General Criteria

Medicaid covers anesthesia services when the surgical, obstetrical, or other diagnostic or therapeutic procedure is approved or is medically necessary and

a. the procedure is consistent with symptoms or confirmed diagnosis of the illness or injury under treatment;
b. the procedure is necessary and consistent with generally accepted professional medical standards (that is, it is not still experimental or investigational);
c. the service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
d. the service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Anesthesia services are not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**
c. the procedure unnecessarily duplicates another provider's procedure; or
d. the procedure is experimental, investigational, or part of a clinical trial.

4.2 Non-Covered Services

4.2.1 Patient-Controlled Anesthesia

Patient-controlled anesthesia is not covered.

4.2.2 Intravenous Sedation and Moderate Conscious Sedation

Moderate sedation does not include general anesthesia, MAC, or regional anesthesia.

Refer to Clinical Coverage Policy #XXX, *Moderate (Conscious) Sedation*, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm, for additional information.

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5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval

When a surgical procedure requires prior approval, it is the responsibility of the surgeon to obtain the prior approval.

5.2 Medical Direction

The anesthesiologist provides medical direction by being physically and personally involved in the care of the recipient simultaneously with the CRNA.

To bill for medical direction, the anesthesiologist must

a. perform the pre-anesthesia evaluation and exam;

b. prescribe the anesthesia;

c. participate personally in the induction of and emergence from the anesthesia procedure;

d. ensure that any part of the anesthesia plan not personally performed by the anesthesiologist is performed by a qualified CRNA;

e. monitor the course of anesthesia administration at frequent intervals;

f. remain physically present and available in the operating suite to provide diagnosis and treatment in an emergency situation; and

g. provide post-anesthesia care, including direct patient care by the anesthesiologist or a qualified provider under the anesthesiologist's supervision.

5.2.1 Clarification of Simultaneous Activities Allowable by an Anesthesiologist during Medical Direction

An anesthesiologist who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area; administering an epidural or caudal anesthetic to ease labor pain; or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, physicians may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting their ability to administer medical direction.

However, if the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case, or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and not reimbursable.

5.3 Time Factors

Anesthesia time involves the **continuous actual physical presence** with the patient of the anesthesiology physician, resident, or CRNA supervised (21 NCAC 36.0226) by a physician or lawfully qualified dentist or oral surgeon. The time starts when the anesthesiologist, resident, or CRNA begins to prepare the patient for anesthesia care in the operating room or equivalent area. Time ends when the anesthesiologist, resident, or CRNA is no longer in personal attendance (that is, when the patient may be safely placed under postoperative supervision). The anesthesiologist, resident, or CRNA must be in constant attendance of the patient during the time billed.

5.4 Anesthesia Global Package

5.4.1 Medical and Surgical Procedures Included in the Global Package

General anesthesia, regional anesthesia, and MAC services are considered a global package of services, and include the following:

a. The usual preoperative and postoperative visits
b. Anesthesia services during the procedure
c. Administration of intravenous fluids including blood and/or blood products
d. Intra-operative laboratory evaluations
e. The usual monitoring services [such as electrocardiogram (ECG), temperature, blood pressure, pulse oximetry, capnography, infrared end-tidal gas analysis, mass spectrography, bispectral electroencephalography, and transcranial Doppler] and their interpretation

These services are not reimbursed separately unless they are unrelated and billed with modifier 59 to indicate a service unrelated to anesthesia services.

5.4.2 Medical and Surgical Procedures Not Included in the Global Package

The following forms of monitoring are not included in the global package:

a. Pulmonary artery catheter insertion
b. Central venous catheter insertion
c. Intra-arterial catheter insertion
d. Nerve blocks for postoperative pain relief (single injections and continuous catheters, including epidural, spinal, and peripheral nerve blockade)
e. Ultrasound-guided central venous access and assisted peripheral nerve blockade
f. Transesophageal echocardiography (TEE) monitoring and interpretation

These forms of monitoring are billed separately, with modifier 59 appended to the procedure code.

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5.5 Types of Anesthesia Services

5.5.1 General Anesthesia

General anesthesia is a controlled and reversible state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including loss of ability to independently maintain airway and respond purposefully to physical stimulation or verbal command. General anesthesia entails amnesia and analgesia, and may or may not include muscle relaxation.

General anesthesia involves the administration and dosing of a variety of pharmacological agents to induce a state of general anesthesia, and includes the intra-operative monitoring of the recipient's vital signs, treatment of adverse physiological reactions, administration of intravenous fluids including blood and/or blood products, interpretation of intra-operative laboratory evaluations, and provision of critical care services.

General anesthesia necessitates the **continuous actual presence of an anesthesiologist, resident, or CRNA** supervised (21 NCAC 36.0226) by a physician or lawfully qualified dentist or oral surgeon, and includes the performance of a preanesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary medications, and provision of indicated postoperative anesthesia care.

5.5.2 Regional Anesthesia

Regional anesthesia is the loss of sensation or motor function to a region of the recipient's body, utilizing pharmacologic agents in the central neuraxis (spinal, epidural, caudal), nerve plexi (cervical plexus, brachial plexus, lumbar plexus, sacral plexus), or individual peripheral nerves. Regional anesthesia involves the intra-operative monitoring of the recipient's vital signs, treatment of adverse physiological reactions, administration of intravenous fluids including blood and/or blood products, interpretation of intra-operative laboratory evaluations, and the ability to convert to general anesthesia if necessary.

Regional anesthesia necessitates the **continuous actual presence of an anesthesiologist, resident, or CRNA** supervised (21 NCAC 36.0226) by a physician or lawfully qualified dentist or oral surgeon, and includes the performance of a preanesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary medications, and provision of indicated postoperative anesthesia care.

5.5.3 Monitored Anesthesia Care

MAC involves the intra-operative monitoring of the recipient's vital physiological signs, in anticipation of either the need for administration of general anesthesia or an adverse physiological reaction to surgery.

Monitoring of a patient in anticipation of the need for administration of general anesthesia during a surgical or other procedure requires careful and continuous evaluation of various vital physiological functions and the recognition and subsequent treatment of any adverse changes.

MAC necessitates the **continuous actual presence of an anesthesiologist, resident, or CRNA** supervised (21 NCAC 36.0226) by a physician or lawfully qualified dentist or oral surgeon, and includes the performance of a preanesthetic

examination and evaluation, prescription of the anesthesia care required, administration of any necessary medications, and provision of indicated postoperative anesthesia care.

5.5.4 Pain Management

Peripheral nerve blocks, plexus blocks, and epidural and caudal blocks administered for postoperative or intractable pain are covered.

5.5.5 Local Anesthesia

Local anesthesia is defined as a volume of local anesthetic that is injected into the cutaneous and subcutaneous tissue only, and provides loss of sensation to pain in a limited area of the body. The administration of local anesthesia is included in the fee for the procedure; therefore there is no separate reimbursement if the operating physician performs an anesthesia-related service such as an injection of a local, field, or regional block.

5.5.6 Oral Procedures

Refer to Clinical Coverage Policy #4A, *Dental Services*, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm for information on anesthesia for oral procedures.

5.6 Limitations

5.6.1 Epidural Catheter

Only one follow-up code (daily hospital management of continuous epidural or subarachnoid drug administration performed after insertion of an epidural or subarachnoid catheter) is covered per day. The code includes all related services performed on that day, such as the visit, removal or adjustment of the catheter, dose calculation, and administration of the drug.

5.6.2 Multiple Procedures Performed on the Same Date of Service

Reimbursement for anesthesia services associated with multiple surgical procedures is determined based on the base unit of the procedure with the highest base unit value and time units based on the actual anesthesia time of the multiple procedures.

Providers are not required to submit medical records documenting the codes and time for the two surgeries; however, medical records must be provided upon request. (See **Section 7.0** for additional information.)

5.6.3 Labor, Delivery, or Sterilization

Combinations of labor, delivery, or sterilization under general or epidural anesthesia are covered for the same patient encounter (which may include overlapping dates of service); however, the sterilization will have cutback pricing applied and both services will be allowed. Refer to **Attachment A** for additional information.

If the recipient is brought back to the delivery room or operating room after labor and delivery or after cesarean section, even if on the same day of service, to perform a subsequent sterilization procedure, then report anesthesia CPT code 00851 as a separate procedure, and include total time units. This applies to all sterilization procedures performed under general anesthesia, regional anesthesia, or MAC. Refer to **Attachment A** for additional information.

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5.7 Qualifying Circumstances

Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. These conditions are reported as one unit of service in addition to the primary procedure and would not be reported alone.

5.7.1 Anesthesia for Patient of Extreme Age

Report for patients under 1 year and over 70 years of age.

5.7.2 Total Body Hypothermia

Anesthesia complicated by utilization of total body hypothermia is covered if hypothermia is due to the type of surgery being performed (for example, open heart or brain surgery).

5.7.3 Controlled Hypotension

Anesthesia complicated by utilization of controlled hypotension is covered when hypotension is due to the type of surgery being performed (for example, open heart or brain surgery).

5.7.4 Emergency Conditions

Report for anesthesia complicated by an emergency if delay in the provision of surgery may lead to a significant increase in the threat to life or body part.

5.8 Anesthesia Stand-by

Anesthesia stand-by services are covered for high-risk deliveries when the appropriate diagnosis code is used and no other anesthesia services are provided. (Refer to Clinical Coverage Policy #XXX, *Obstetrics,* for more information.)

5.9 Evaluation and Management Codes and Anesthesia

The global anesthesia package includes the preoperative evaluation; the prescription of the anesthetic plan; the provision of general anesthesia, regional anesthesia, or MAC; the routine intra-operative monitoring and laboratory evaluation; the administration of intravenous fluids including blood and/or blood products; the immediate postoperative care; and a postoperative visit if applicable.

Critical care evaluation and management (E/M) codes and respiratory care–ventilator management E/M services are covered if extended care is required beyond the immediate postoperative period. Bill separately with modifier 25 appended.

5.9.1 Termination of Surgery

If a surgery is terminated after the preanesthesia evaluation and examination is performed, the physician may bill an E/M service if the criteria for E/M services are met. The documentation must support the level of service provided.

If induction of anesthesia begins, reimbursement will be based on the CPT procedure code base units plus actual time.

5.10 Anesthesia Consultations

The attending physician or other appropriate source must request consultations, and the need for the consultation must be documented in the recipient's medical record.

The consultant's opinion and any services that are ordered or performed must also be documented in the recipient's medical record and communicated by written report to the requesting physician or other appropriate source.

Routine preoperative visits are not considered consultations. Medicaid follows CPT E/M definitions of consultations.

6.0 Providers Eligible to Bill for the Service

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for anesthesia services when anesthesia is within the scope of their practice:

a. Physicians enrolled as anesthesiologists
b. Physician groups enrolled as anesthesiology groups
c. Anesthesiologists enrolled as multi-specialty groups
d. CRNAs when supervised (21 NCAC 36.0226) by an anesthesiologist or operating surgeon

Other licensed physicians may bill 01967, epidural analgesia for planned vaginal delivery, if it is within the scope of their practice and they have been granted privileges to perform the procedure by the institution where the service is being delivered.

7.0 Additional Requirements

7.1 Medical Records

7.1.1 Records Retention

As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program [Social Security Act 1902(a)(27) and 42 CFR 431.107]. Records must be retained for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107).

Copies of records must be furnished upon request.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

7.1.2 Documentation

Medical record documentation is reviewed to determine medical necessity and to verify that services were billed correctly. Documentation must

a. support services rendered and include documentation of the preanesthetic examination and evaluation, beginning and end times of anesthesia, documentation of the monitoring of the recipient's vital signs, and any postoperative anesthesia notes;
b. support the codes reported on the health insurance claim form or billing statement to indicate services were provided; and
c. indicate medical direction.

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7.2 Regulatory Requirements

All providers must comply with all applicable federal and state regulations and laws. If the primary surgeon's claim is denied because federal regulations were not met, claims for the anesthesiologist also are denied.

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2003

Revision Information:

Date	Section Revised	Change

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Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Dental (ADA/837D transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Reimbursement for anesthesia follows CPT anesthesia guidelines. Providers bill for anesthesia services using one of the 5-digit CPT anesthesia codes or the appropriate ADA procedure codes, and appropriate CPT codes for qualifying circumstances. The CPT anesthesia codes are also used for labor and delivery.

The dental codes for sedation are

D9220	Deep sedation/general anesthesia—first 30 minutes
D9221	Deep sedation/general anesthesia—each additional 15 minutes

Qualifying CPT Codes for 99140

99140	Anesthesia complicated by emergency conditions (specify)(List separately in addition to code for primary anesthesia procedure).
Procedure Code	**Description**
00210	Anesthesia for intracranial procedures; not otherwise specified
00212	Anesthesia for intracranial procedures; subdural taps
00214	Anesthesia for intracranial procedures; burr holes, including ventriculography
00215	Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)
00400*	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified
00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified
00541	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator

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Qualifying CPT Codes for 99140, continued

99140	Anesthesia complicated by emergency conditions (specify)(List separately in addition to code for primary anesthesia procedure).
Procedure Code	**Description**
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator
00563	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest
00770	Anesthesia for all procedures on major abdominal blood vessels
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00880	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified
00882	Anesthesia for procedures on major lower abdominal vessels; inferior vena cava ligation
01961	Anesthesia for cesarean delivery only
01962	Anesthesia for urgent hysterectomy following delivery
01965	Anesthesia for incomplete or missed abortion procedures
01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)

*Procedure code 99140 is reimbursable with 00400 for burns or compartment syndrome only.

Qualifying CPT Codes for 99116 or 99135

99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)
Procedure Code	**Description**
00210	Anesthesia for intracranial procedures; not otherwise specified
00215	Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)
00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified
00541	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator

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Qualifying CPT Codes for 99116 or 99135, continued

99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)
Procedure Code	**Description**
00563	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator with hypothermic circulatory arrest
00770	Anesthesia for all procedures on major abdominal blood vessels
00880	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified
00882	Anesthesia for procedures on major lower abdominal vessels; inferior vena cava ligation

D. Modifiers

Providers are required to follow applicable modifier guidelines. One of the following modifiers must be appended to the anesthesia CPT code each time anesthesia is billed by provider specialty anesthesiology or a CRNA:

AA	Anesthesia services performed personally by anesthesiologist
QY	Medical direction of 1 CRNA by an anesthesiologist
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures
QZ	CRNA service: without medical direction by a physician
QX	CRNA service: with medical direction by a physician

Claims for all other provider specialties with anesthesia modifiers will be denied; however, all providers are subject to modifier guidelines.

Monitored Anesthesia Care Service (indicated by modifier QS)

When MAC is billed, the QS modifier is informational only. Anesthesiologists and CRNAs must also append modifier AA, AD, QZ, QK, QX, or QY.

Unrelated Service

Anesthesiology services are not limited to the provision of general anesthesia, regional anesthesia, or MAC. Providers must use modifier 59 to indicate when a procedure is unrelated to the administration of anesthesia and should be considered for separate reimbursement (such as invasive monitoring devices, continuous transesophageal echocardiographic (TEE) monitoring, post-operative pain relief blocks, etc.). Documentation must support using modifier 59.

E. Billing for Medical Direction

When an anesthesiologist provides medical direction, either modifier QY or QK must be appended to the anesthesia CPT code. Modifier QX must be appended to the CPT code billed on the CRNA claim. Refer to **Attachment B** for additional information.

CRNA Employed by a Hospital or Facility

1. The CRNA professional charges are billed on the hospital's professional claim form.
2. Modifier QX must be appended to the CPT code.
3. The hospital's billing provider number is entered in block 33 of the CMS-1500 claim form.
4. The CRNA's attending number is entered in the attending area in block 33 of the CMS-1500 claim.
5. The hospital's facility charges are billed on the UB-04 claim form with revenue codes (RC) in the 37X range. Only the facility charges are included in the RC code.
6. The anesthesiologist performing medical direction appends either modifier QY or QK to the anesthesia CPT code.

CRNA Employed by an Anesthesiologist

1. The anesthesiologist bills the medical direction by appending modifier QK or QY to the CPT code on the physician claim.
2. The physician's group provider number is placed in block 33 of the CMS-1500 claim form.
3. Report the physician's individual provider number in the attending area of block 33.
4. The CRNA services are billed on a separate CMS-1500 claim form with the medical direction modifier QX appended to the CPT code.
5. The physician group's provider number is entered in block 33.
6. The CRNA's provider number is placed in block 33 in the attending area.

F. Billing for Services Provided without Medical Direction

Refer to **Attachment B** for additional information.

The AA modifier indicates that no medical direction was provided to a CRNA, and the entire service was performed personally by the anesthesiologist.

If a CRNA performs the service without medical direction, the QZ modifier must be appended to the anesthesia CPT code.

The AD modifier indicates that medical supervision was provided to a CRNA (5 or more concurrent cases being supervised (21 NCAC 36.0226) by the anesthesiologist) and the QZ modifier must be appended to the anesthesia CPT code. The anesthesiologist will be reimbursed 45 base units for every procedure being supervised, and may bill a one-time 15-minute block of time if the anesthesiologist can document presence at anesthetic induction on the medical record.

CRNA Employed by a Hospital or Facility

1. The hospital bills the CRNA professional charges on the CMS-1500 claim form.
2. The hospital's billing provider number is entered in the group area in block 33.
3. The CRNA's provider number is entered as the attending number in block 33.
4. Modifier QZ must be appended to the CPT code.
5. The hospital's facility charges are billed on the UB-04 claim form.
6. An RC (revenue code) in the 37X range must be used.
7. Only the facility charges are included in the RC. CRNA professional charges must not be included in the RC.

CRNA Employed by an Anesthesiologist

1. The CRNA services are billed on the CMS-1500 claim form.
2. The physician's group provider number is entered in block 33.
3. The CRNA's provider number is entered in the attending field of block 33.
4. Modifier QZ is appended to the CPT code.

G. Billing for Services Provided by Anesthesiology Residents under the Supervision of Teaching Anesthesiologists in Graduate Medical Education Programs

An unreduced fee schedule payment will be made if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching anesthesiologist must document in the medical records that s/he was present during all critical (or key) portions of the procedure. The teaching anesthesiologist's physical presence during only the preoperative or postoperative visits with the beneficiary is not sufficient to receive payment. If an anesthesiologist is involved in concurrent procedures with a resident and a non-physician anesthetist, Medicaid pays for the anesthesiologist's services as medical direction.

In those cases in which the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time s/he is present with the resident. The teaching anesthesiologist can bill base units if s/he is present with the resident throughout pre- and postanesthesia care. The teaching anesthesiologist should use the "AA" modifier to report such cases. The teaching anesthesiologist must document his or her involvement in cases with residents. The documentation must be sufficient to support the payment of the fee and available for review upon request.

H. Billing for Dental Anesthesia

The following guidelines apply to dental anesthesia:

1. Physicians and CRNAs administering anesthesia for dental procedures bill anesthesia CPT procedure codes. In block 24G of the CMS-1500, the anesthesia time is entered as "1 minute = 1 unit."
2. Anesthesiologists and CRNAs billing for anesthesia services rendered in an ambulatory surgical center (ASC) or hospital use the CMS-1500 claim form.
3. If analgesia or anesthesia is rendered in the dental office, the dentist providing the analgesia or anesthesia bills for it using the appropriate ADA procedure codes.

For additional information, refer to **Attachment B** of this policy and to Clinical Coverage Policy #4A, *Dental Services,* on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm. The Board of Dental Examiners credentialing process for general anesthesia is on their Web site at http://www.ncdentalboard.org/pdf/RulesRevised.pdf.

I. Billing Anesthesia for Labor, Delivery, and/or Sterilization Procedures

Refer to **Attachment C** for more information.

The following guidelines apply to billing anesthesia services for **sterilization** procedures:

1. CPT anesthesia procedure codes used for a sterilization procedure must be billed with ICD-9-CM diagnosis code V25.2 and modifier FP appended to the code.
2. The CPT anesthesia procedure codes that may be used for sterilization are 00840, 00851, and 00921.

3. Anesthesia reimbursement for a sterilization procedure is cut back to a flat fee when billed in conjunction with labor and delivery.

The following guidelines apply to billing anesthesia services for **obstetrical** procedures.

1. The maximum unit limitation for the following obstetric anesthesia procedures that are billed with units of time is 180 units (minutes) per date of service:
   a. Anesthesia for vaginal delivery only
   b. Anesthesia for cesarean delivery only
   c. Anesthesia for urgent hysterectomy following delivery
   d. Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia
   e. Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia

   Units billed exceeding 180 will be cut back and payment will be made for only 180 units. An adjustment with medical records to support the need for additional units must be submitted for consideration of additional payment. Documentation must always support all units billed and services rendered.
2. Obstetric add-on codes 01968 and 01969 may be billed by the same or a different provider when billed within 48 hours of the primary procedure code 01967.

When anesthesia is provided for a vaginal delivery immediately followed by a sterilization procedure, anesthesia for the delivery is paid at 100% of the calculated amount (base units plus time units; total units are multiplied by the anesthesia conversion factor) and the sterilization flat fee cutback applies. Refer to **Attachment D** for more information.

J. Billing for Epidural Injections for Pain Management

Only one charge of code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) performed after insertion of an epidural or subarachnoid catheter is allowed per day, and includes all related services performed on that day, such as the visit, removal or adjustment of the catheter, dose calculation, and administration of the drug. In addition, this service does not require the use of anesthesia modifiers and may be billed by all physician specialties.

K. Billing for Pain Management Procedures

These procedures are not reimbursable by time, and therefore the appropriate CPT codes shall be submitted and units should correspond to the number of services rendered. If the injection or insertion of the block or continuous catheter is performed primarily for the management of postoperative pain, the appropriate procedure code is billed with modifier 59 to designate the service is separately reportable and is not bundled with the anesthesia global service.

L. Billing Units

Providers must report the time for all general and monitored anesthesia services as 1 minute = 1 unit.

Medicaid does not recognize time units for anesthesia codes 01967, neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid

needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor), or 01996 (daily hospital management of epidural or subarachnoid continuous drug administration). A flat rate for 1 unit per occurrence is allowed.

M. Place of Service

Inpatient Hospital
Outpatient Hospital
Ambulatory Surgery Center
Office

N. Reimbursement Rate

Providers must bill their usual and customary charges. N.C. Medicaid accepts actual time when billing for anesthesia services. Report time in minutes in the units field (Item 24g) of the CMS-1500 claim form.

Calculating Payment Rates

Each procedure approved for billing anesthesia is assigned base units according to the complexity of the procedure. The time units billed plus the assigned base units are used to calculate the reimbursement for the anesthesia services. Claims submitted by provider should reflect time only; base units are automatically calculated for the reported procedure code.

Payment for anesthesia services is calculated as follows:

1. If personally performed by the anesthesiologist, (Base units + time) x anesthesia rate x physician conversion factor (100%) = physician payment
2. If personally performed by the CRNA, (Base units + time) x anesthesia rate x CRNA conversion factor (90%) = CRNA payment
3. If medically directed, the physician allowable is divided equally (50%) between the anesthesiologist and the CRNA.
4. If medically supervised, the physician allowable is 45 base units for every procedure being supervised, and a one-time, 15-minute block of time may be billed if the anesthesiologist can document presence at anesthetic induction on the medical record.

If surgery is delayed and the provider of anesthesia is not in constant attendance, the time billed must be reduced to reflect the actual time spent with the recipient.

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Attachment B: Billing Guidelines for Anesthesia Services with and without Medical Direction

Provider Rendering Service	Billing Provider	CMS-1500 Claim Form	UB-04 Claim Form
Anesthesiologist personally performs entire service	Anesthesiologist	AA is appended to the anesthesia CPT code	No
Anesthesiologist medically supervises 5 or more CRNAs	Anesthesiologist	AD is appended to the anesthesia CPT code	No
CRNA employed by hospital, performing **without** medical direction	Hospital facility charge	No	Bills RC 37X range
	CRNA professional charge	Hospital professional number and CRNA/AA number in block 33; append QZ modifier to CPT code	No
	Surgeon	Bills CPT code	No
CRNA employed by hospital, performing **with** medical direction	Hospital facility charge	No	Bills RC 37X range
	CRNA professional charge	Hospital professional number and CRNA number in block 33; append QX to CPT code	No
	Anesthesiologist providing medical direction	If 1 CRNA, append QY to CPT code. If 2, 3, or 4 CRNAs, append QK to CPT code.	No
CRNA employed by anesthesiologist, performing **with** medical direction	Hospital facility charge	No	Bills RC 37X range
	CRNA professional charge	QX is appended to the CPT code. Use anesthesiology group/attending number in block 33.	No
	Anesthesiologist providing medical direction	On separate claim, append QY to the CPT if 1 CRNA. If 2, 3, or 4 CRNAs, append QK. Bill group/attending number in block 33.	No
CRNA employed by anesthesiologist, performing **without** medical direction or is medically supervised by anesthesiologist	Hospital facility charge	No	Bills RC 37X range
	CRNA professional charge	QZ is appended to the CPT code. Anesthesia group bills group/attending in block 33.	No

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Attachment C: Billing Combinations of Labor, Delivery, and Sterilization

The following table summarizes guidelines for billing combinations of labor, delivery, and sterilization with anesthesia. If the sterilization is billed in addition to a delivery (01960, 01961, 01968), the sterilization will have cutback pricing applied and both services will be allowed.

Procedure	Code	Remarks	Time Units
Delivery under epidural, sterilization under general or epidural	01967 **and**	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor) **and**	1 unit (flat rate)
	01968 **plus**	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) **plus**	1 minute = 1 unit
	00840 **or** 00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified **or** Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction (Use diagnosis code V25.2)	Cutback pricing applies
	01967 **and**	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor) **and**	1 unit (flat rate)
	00840 **or** 00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified **or** Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction (Use diagnosis code V25.2)	Cutback pricing applies

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Procedure	Code	Remarks	Time Units
Delivery under general, sterilization under general or epidural	01960 **and**	Anesthesia for vaginal delivery only **and**	1 minute = 1 unit
	00840 **or** 00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified **or** Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction (Use diagnosis code V25.2)	Cutback pricing applies
	01961 **and**	Anesthesia for cesarean delivery only **and**	1 minute = 1 unit
	00840 **or** 00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified **or** Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction (Use diagnosis code V25.2)	Cutback pricing applies
C-section hysterectomy after labor under epidural or spinal anesthesia	01967 **and**	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)	1 unit (flat rate)
	01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)	1 minute = 1 unit
C-section delivery	01961	Anesthesia for cesarean delivery only	1 minute = 1 unit